# Town of Brookline
## Health Reimbursement Arrangement (HRA) Voucher
### JULY 1, 2014 TO JUNE 30, 2015

**CPA, INC.**
**420 Washington Street, Suite 100**
**Braintree, MA 02184**

**info@cpa125.com**
**(781) 848-8477 (Fax)**
**(781) 848-9848 (Phone)**

**EMPLOYEE:** _____ **SS#:** _XXX_ -_XX_ -_____

**ADDRESS:** _____ **CITY:** _____

**STATE:** _____ **ZIP:** _____ **PHONE:** (  ) _____ **E-MAIL:** _____

**NAME OF MEMBER INCURRING THE CLAIM:** _____

Reimbursement for subscriber and family members enrolled in
Non-Medicare group health plans through the GIC/Town of Brookline.
ALL EXPENSES MUST BE INCURRED BETWEEN JULY 1, 2014 THROUGH JUNE 30, 2015.

| **Type of Medical Care COPAY Expenses** | **Co-pay charged** | **Reimbursable Amount** | **Date of Service/ Bill Date** | **Total Reimbursement** |
|---|---|---|---|---|
| ***Example:*** *ER co-pay* | *$100.00* | *$50.00* | *7/25/14* | *$50* |
| Out-patient Day Surgery | | $150.00 | | |
| Inpatient Hospital Admission | | $500.00 | | |
| Emergency Room | | $50.00 | | |
| High-Tech Imaging | | $100.00 | | |

**TOTAL CLAIM AMOUNT: $_____**

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under my employer's co-payment Reimbursement Arrangement. I have not been reimbursed from any other source including insurance programs or other programs offered by my employer. None of these expenses have previously been submitted. I understand and agree that since these expenses are to be reimbursed they may not be claimed as deductions for income tax purposes. I hereby request reimbursement for these claims.

**All medical claims submitted require copies of original invoices, receipts or claim summaries from your insurance company. Eligible co-payment for reimbursement include:** up to $150 for out-patient day surgery co-pays, up to $500.00 for inpatient hospital admission co-pays, $50.00 for Emergency Room co-pays and $100.00 for High-Tech imaging co-pays (MRI, CT scan, PET scan) for members requiring three or more high-tech imaging services that result directly from a serious and/or chronic medical condition.

**PARTICIPANT'S SIGNATURE:** _____ **DATE:** _____